"Fluoroscopic examination of the chest; no abnormality.

"The stomach outlines are smooth, peristalsis is not increased, and there is no delay in emptying. The antrum is not spastic. The duodenal bulb fills readily, smooth in outline, and empties normally. The course of the duodenum is regular.

"Films taken at fifteen minutes, thirty minutes, one hour, two hours, four hours, and six hours show normal distribution of the meal through the small intestines, and no abnormality is noted.

"At six hours distribution is normal, the stomach being empty.

"At twenty-four hours barium is well distributed throughout the large bowel. The cecum has begun to empty, is movable and not tender."

Biopsy.—A biopsy of the left parotid gland was done by Dr. Frederick Foote under local anesthesia. His report is as follows:

"Grossly, this enlargement appeared to be of the gland itself, with the tissue thrown up in nodules. On cutting through it, the gland appeared to be particularly meaty, with small areas of cystic dilatation. These small cysts appeared to contain saliva."

The tissue was sent to Dr. Jesse L. Carr for examination. His report follows:

"Sections show an effuse replacement of the gland by large fields of lymphocytes between which are small islands of cells which are larger, more pale staining, and closely knit. Through this whole mass run dilated salivary ducts which are filled with granular blue coagulum. No normal gland remains.

"Pathologic diagnosis: Mikulicz's disease."

Diagnosis: Mikulicz's disease; chronic colitis; achylia.

Further Course.—X-ray treatment of the parotid glands was followed by rapid reduction in size to normal.

COMMENT

The question arises as to whether the bacterial colitis and achylia may have had an etiologic relation to the parotitis. The achylia may have predisposed to abnormal bacterial flora in the colon. The colonic bacteria, especially some of the streptococci, may have been involved. Of this we have no proof. The upper respiratory infections immediately preceding the parotid enlargement are apparently more closely related to the parotitis. Failing recovery of bacteria from biopsy material from the affected glands, the question of bacterial relations cannot be settled in this case, and we did not think of biopsy tissue culture until too late.

350 Post Street.

CATASTROPHIES FOLLOWING HEMORRHOID INJECTIONS*

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THE injection treatment for internal hemorrhoids, when bleeding at stool is the only symptom, is based on sound therapeutic principles. In selected cases the results are excellent. Injection may sometimes be used as a palliative measure when the hemorrhoids protrude through the anal orifice. The technique of injection is not easy and requires much practice. All this has been said hundreds of times, but no one seems to have called attention to the disastrous sequelae which often follow hemorrhoid injections.

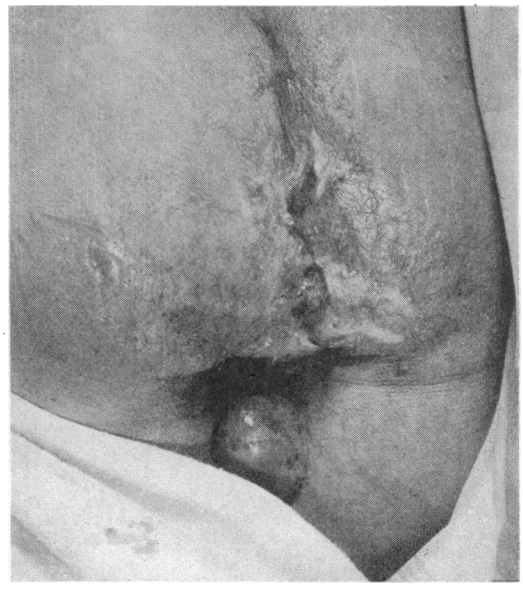

Fig. 1.—Photograph of the perineum of a male patient nineteen days after an injection treatment for internal hemorrhoids. The lower rectum and anus have sloughed away. The patient now has four anal orifices, with no control of bowels or bladder. This patient won a large award in a malpractice suit, but he has lost his rectum.

Gabriel reports a case of a patient with tubular stricture necessitating colostomy as a sequel to an injection treatment. Some rectal surgeons are opposed to any injections, and I predict that in the future we shall all use this treatment less frequently and with much greater discrimination.

The following is a summarized list of the more severe complications in patients who have come under my care following injection treatments:

A. Slough (chemical necrosis):
   1. Localized necrosis causing pain, but unattended by other sequelae.
   2. Generalized necrosis resulting in:
      (a) Mechanical hemorrhoidectomy.
      (b) Cellulitis, with sloughing of entire rectum and complete loss of control.
      (c) Septicemia.

B. Abscess (requiring surgical treatment):
   1. Local abscess.
   2. Anorectal fistula.
   3. Abscess terminating in chronic ulcerative proctitis and colitis.

C. Injury to contiguous structures:
   1. Rectovaginal fistula.
   2. Periprostatic abscess.
   3. Epididymitis.
   4. Vesiculitis with urethral hemorrhage.

D. Severe secondary hemorrhage.

I do not advocate hemorrhoidectomy in all patients with internal hemorrhoids. This operation is attended by some slight risk, and the patient needs to be away from his work for two weeks. The operation offers, however, the only cure, and injection treatments might do more harm than good.

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